

**Bureau of Mines and Mine Safety
Final Report
Date: August 18th, 2014
Fatality Report From
March 25th, 2014
Gibson County Coal LLC
Gibson Mine
Prepared by Donald "Blink" McCorkle
Assistant Commissioner**

Authority for Inspection

The Bureau of Mines and Mine Safety (herein the "Bureau of Mines") exists as a bureau within the department of Labor by virtue of Ind. Code 22-1-1-4(1). Ind. Code 22-1-1-5(a) (4) requires the Bureau of Mines to investigate all fatalities occurring in underground mine operations for the purpose of data collection. Ind. Code 22-10-3-6 grants the Director (hereinafter the Assistant Commissioner of the Bureau of Mines) the authority to enter, examine, and inspect all commercial coal mines and facilities. Pursuant to 30 U.S.C. 801 et seq., (the Federal Mine Safety and Health Act of 1977, hereinafter "the act"), the Interagency agreement Between the Mine Safety and Health Administration U.S. Department of Labor dated March 29, 1979, the Mine Safety and Health Administration (hereinafter "MSHA") has jurisdiction over coal mines and each operator of a coal mine.

The investigation of this accident was done by the federal office of MSHA District 8 office in Vincennes, Indiana. MSHA was the lead investigator, with the Indiana Bureau of Mines accompanying MSHA pursuant to Indiana law for the purpose of collecting data. Indiana Code 22-1-1-5 provides that the investigation of the Bureau of Mines shall not interfere with the investigations by MSHA. As nothing in state law gives the Bureau of Mines authority to assess fines, issue citations, or enforce abatement orders, the doctrine of preemption clearly accords federal MSHA the primary role as investigator.

MINE'S BACKGROUND

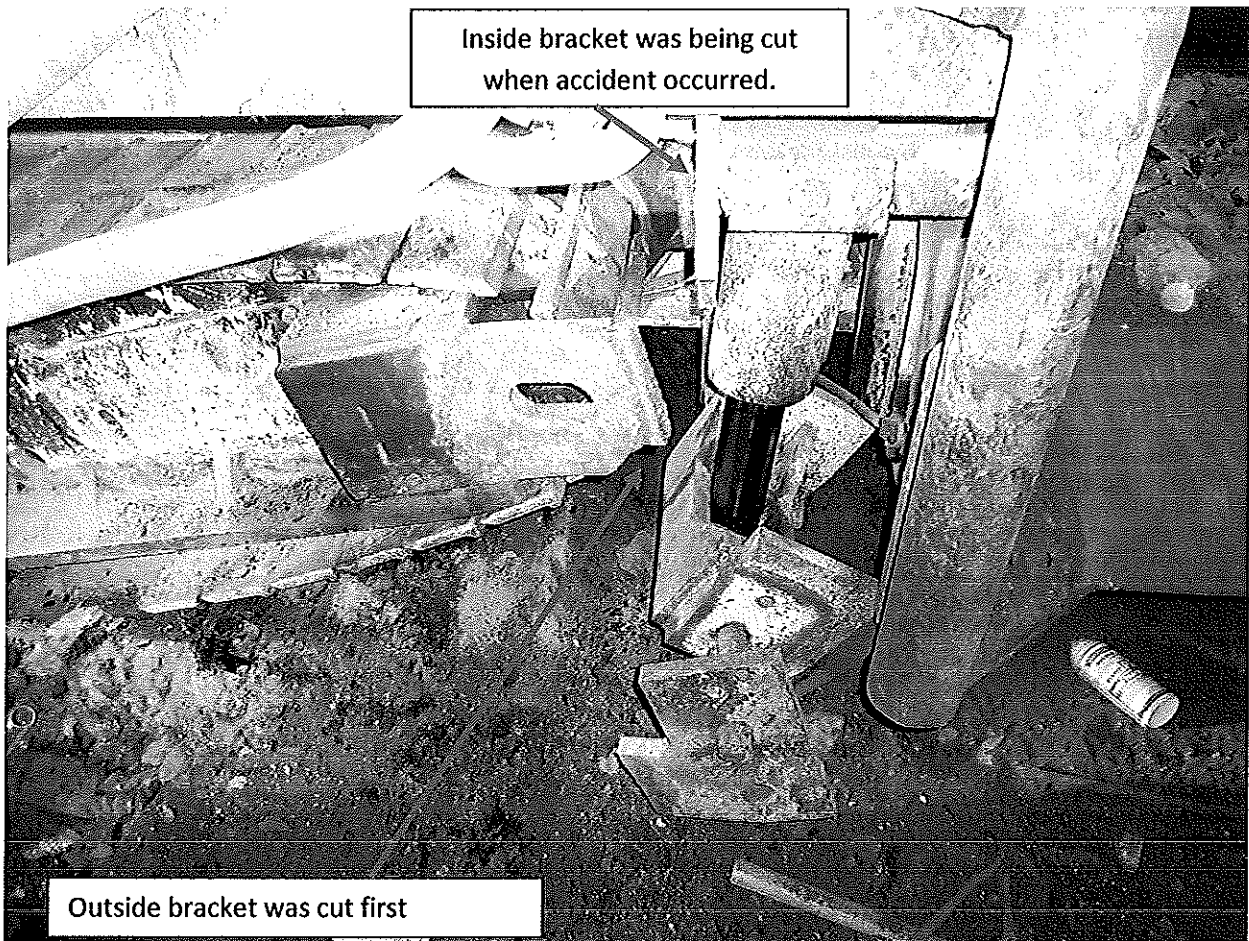
Gibson County Coal's Gibson mine is located in Gibson County two miles northwest of Princeton, Indiana. The mine's MSHA ID number is 12-02215. The mine employs 376 miners. The coal seam mined is the Springfield #5 coal seam. The mine started production in July 1999.

Overview of Accident

At approximately 1:45 am central standard time, on March 25th, 2014, a 41 year old mechanic trainee with 23 weeks of mining experience was fatally injured at the Gibson County Coal LLC, Gibson Mine on Unit #4 in #6 entry of the 3rd Northwest panel, while working on a AWI #4 belt feeder, company ID #7024. The victim was cutting through the inner left side plate of the crawler assembly, which connects the hopper jack assemblies to the crawler frame. After making the outside cut on the plate the victim positioned himself on the crawler frame, leaning in to make the inside cut on the plate, putting himself in between the crawler frame assembly and the feeder frame, when this cut was completed the crawler assembly pivoted upward pinning the victim between the crawler assembly and the frame of the feeder.



(1)



Inside bracket was being cut
when accident occurred.

Outside bracket was cut first



(3)



(4)

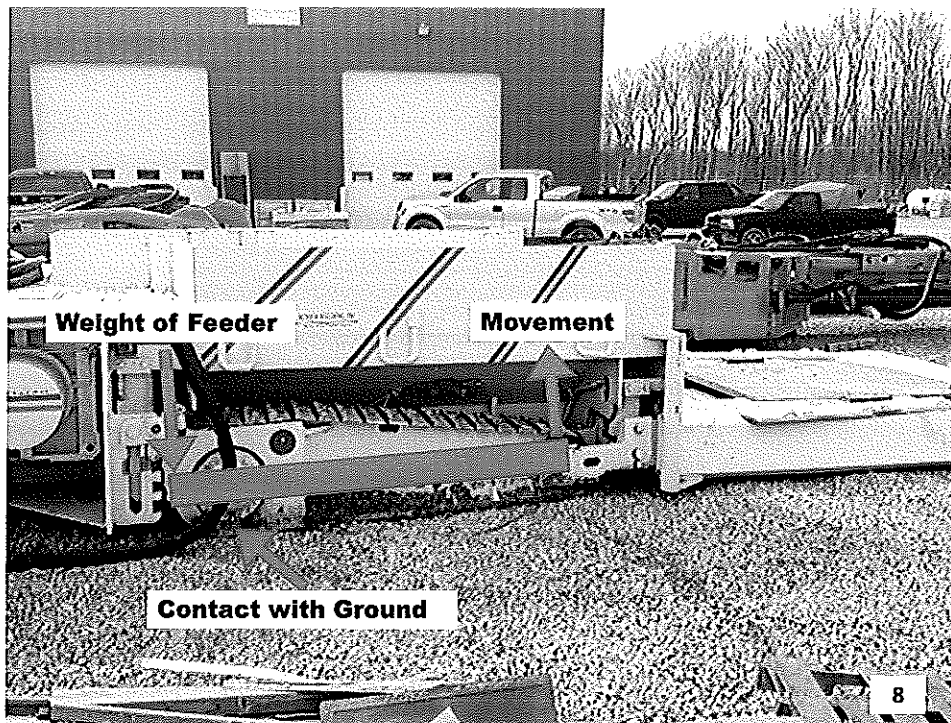
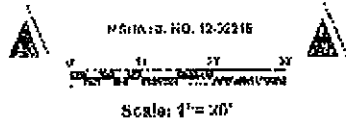


Figure 5

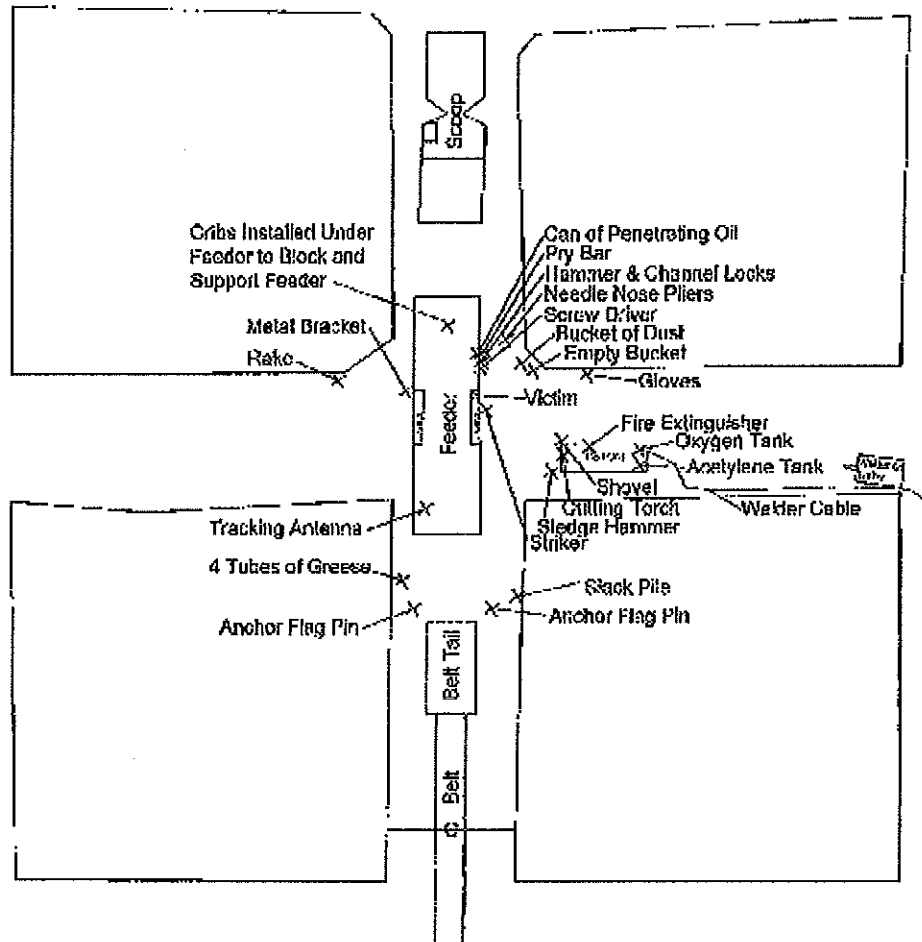
(5)

Gibson County Coal, LLC.



25 March 2014

Draft 3/26/14 7:20 A.M.



TIME LINE OF EVENTS BEFORE ACCIDENT

On midnight shift on March 25th, 2014, which started at 11:00 pm central time, the maintenance and idle crew members were given work assignments to do on Unit #4. Unit #4 is super section having multiple pieces of equipment.

At the start of the shift Christopher Lee Horton, mechanic and Tim Memmer, victim, were assigned by Jason Hosick, Maintenance Foreman, to work on the #4 unit feeder on unit #4 to replace the brackets that connect the hopper jacks to the frame, because they were damaged. This was a job that neither of them had done before. Memmer and Horton gathered the tools they would need at the bottom area's mechanic shack and a welding cart at the start of their shift then proceeded to unit #4 to do the job, arriving at approximately 11:53 p.m. with Horton following Memmer on a diesel man trip.

After Memmer and Horton arrived on the unit they set a welder and torches to repair the feeder. They moved the feeder to the inby intersection to have more working space around the feeder. (See accident area diagram showing feeder moved from the belt tail to the intersection.) Horton positioned the feeder in the intersection then actuated the lift cylinders to elevate the hopper end of the feeder (see diagram #5). Memmer, Horton, and Steve Waldern, Mechanic, then built a crib underneath the center of the hopper end of the feeder to block the hopper. (See accident area diagram and figure #5 for location of hopper.)

DESCRIPTION OF THE ACCIDENT

Horton actuated the feeder hopper jack control valve to relieve pressure from the hopper jack pin. Horton crawled under the hopper end of the feeder to remove the jack pin retaining bolt and jack pin bracket bolts using a cutting torch. Horton then handed the torch to Memmer to cut the jack pin retaining bolt and jack pin bracket bolts that were on the outside of the pin and bracket. From underneath the feeder, Horton then hit the jack pin with a hammer outward as far as he could, but he could not hammer the pin all the way out because his pin hammer was not long enough. Because of the close proximity of the feeder frame, there was not enough room to use a longer tool to knock the pin out. Horton crawled out from under the feeder. Horton and Memmer agreed that the two side plates should be cut in two and removed. Memmer used the torch to cut through the outside plate first. Horton crawled back under the feeder and attempted to hit the hopper jack end of the outside plate off with a sledgehammer, but was not successful. Horton was going to stay underneath the feeder to cut the inner plate, but Memmer said he would just cut it from his position on the outside. Memmer then leaned over the top of the cat track to access the inner side plate with the torch. Memmer was using the torch with his left hand and was facing inby. Horton went to the opposite side of the feeder to gather parts from the diesel mantrip and bring them to the side of the feeder being repaired. Horton took one of the replacement plates to the side of the feeder where Memmer was working and watched him cut partially through the inner side plate. Horton then started walking back to the opposite side of the feeder to get the other replacement plate. As Horton was walking away, Memmer said he had almost cut through the plate. At approximately 1:45 a.m., Horton heard a loud "pop." Horton turned around and saw Memmer pinned between the top of the cat track and the bottom of the hopper. Horton tried to make contact with Memmer by shaking him and asking if he

was okay. He did not get any response from Memmer. Horton then ran inby to the next intersection and yelled for help.

Walden, John Cooley, and Chris Cooper, Mechanics, heard Horton yelling for help. Horton told them that Memmer was hurt badly. At the feeder, Walden observed the victim pinned and informed Shawn Kelley, Third Shift Maintenance Foreman via mine phone. Cooley observed that the victim was pinned by the head and arm and he was severely injured. Upon arrival at the feeder, Victor Banet, Third Shift Unit Leadman, told Walden to phone for the underground ambulance. Banet brought the scoop to the hopper end of the feeder. Chris Burkett, Third Shift Foreman, and Ryan Carey, Laborer, arrived on the section. Carey, who was an experienced scoop operator, operated the scoop to lift the feeder hopper. Banet and Cooley removed Memmer from the feeder pinch point as Carey lifted the hopper end of the feeder with the battery scoop. Cooper laid Memmer down on the mine floor and Banet attempted resuscitation by starting chest compressions.

Jade Dozier, Third Shift Mine Manager, arrived on No. 4 Unit with the underground ambulance. Cooley and Chad Terrell, CO Technician, placed Memmer onto a backboard and then into the underground ambulance. Terrell took over chest compressions on Memmer at this time. At approximately 2:15 a.m., Dozier drove the underground ambulance to the man-shaft. The ambulance was hoisted out of the mine at approximately 2:28 a.m. to the surface, where Gibson County EMS crew and ambulance were waiting. Gibson County EMS assessed Memmer and loaded him into the ambulance. The victim was transported to the Gibson General Hospital, where he was pronounced dead by the emergency room physician, Dr. Keh Ganiyu, at 2:59 a.m.

ROOT CAUSE OF THE ACCIDENT

The work procedure being done on the feeder had not been done before by the men working on that job. There were no safe work procedures in place on how to properly support the feeder from the movement that caused the accident. The mine operator has now submitted written plans to MSHA for properly blocking the feeder so that the feeder will be blocked against any motion while work is being performed, and that the area where the work is being performed meets all other safety provision requirements.

CONCLUSION

The state concurs with the Mine Safety and Health Administration that mine management did not ensure that safe work procedures were established for the job being done. By the feeder not being properly blocked against motion, the victim was not in a safe zone while performing the job thus resulting in the events that followed this action.